STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155272	A. BUILDING 00 B. WING	08/01/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP COD
ALLISON POINTE HEALTHCARE CENTER	5226 E 82ND STREET INDIANAPOLIS, IN 46250

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F 0000 Bldg. 00	This visit was for the Investigation of Complaints IN00434433, IN00434554, IN00435159, IN00435725, IN00437951, IN00438073, IN00438464, and IN00438647. Complaint IN00434433 - Federal/state deficiencies related to the allegations are cited at F550, F684, F755, and F842. Complaint IN00434554 - Federal/state deficiencies related to the allegations are cited at F609 and F610. Complaint IN00435159 - Federal/state deficiencies related to the allegations are cited at F842. Complaint IN00435725 - No deficiencies related to the allegations are cited. Complaint IN00437951 - Federal/state deficiencies related to the allegations are cited at F684 and F842. Complaint IN00438073 - No deficiencies related to the allegations are cited. Complaint IN00438464 - No deficiencies related to the allegations are cited. Complaint IN00438647 - No deficiencies related to the allegations are cited. Unrelated deficiencies are cited at F580 and F697. Survey dates: July 29, 30, 31, August 1, 2024	F 0000	Preparation and execution of this plan of correction does not constitute admission or agreement of provider of the truth of the facts or alleged or conclusions set forth on the State of Deficiencies. The Plan of Correction is prepared and executed solely because it is required by the position of Federal and State Law. The Plan of Correction is submitted in order to respond to the allegation of non-compliance cited during the survey process. Please accept this plan of correction as the provider's credible allegation of compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Paula E Carroll	HFA	08/22/2024

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determin other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclo days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Facility number: 000172 Provider number: 155272 AIM number: 100267130 Census Bed Type: SNF/NF: 105 Total: 105 Census Payor Type: Medicare: 3 Medicaid: 90 Other: 12 Total: 105 These deficiencies reflect State Findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on August 7, 2024.			
F 0550 SS=D Bldg. 00	483.10(a)(1)(2)(b)(1)(2) Resident Rights/Exercise of Rights §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment			

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	source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. Based on interview and record review, the facility failed to ensure a resident's dignity was maintained for 1 of 3 residents reviewed for abuse. (Resident F) Finding include: The clinical record for Resident F was reviewed on 7/31/24 at 9:00 a.m. The diagnosis included, but was not limited to, below the knee amputation (BKA). The Admission Minimum Data Set (MDS) assessment, dated 5/13/24, indicated Resident F was cognitively intact. An interview was conducted with Resident F on	F 0550	**F550 Resident Rights/Exercise of Rights Respect and Dignity** **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?** Resident F was followed up with Social Services on 8/01/2024, 8/02/2024 and 8/05/2024 to ensure psychosocial needs had been met. Facility completed education with LPN Three on 08/05/2024 on Resident Rights. **How will you identify other**	08/30/2024

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	7/31/24 at 9:39 a.m. He indicated a night shift nurse, Licensed Practical Nurse (LPN) 3, does not like him. He can't remember for sure what day, but believed, on 7/24/24, he had requested some pain medication from LPN 3. LPN 3 had responded to him and how she had just given him his medications and he was "f****** p****** her off." During that time, LPN 3 had called him a drug addict. The resident indicated he and LPN 3 were cussing at each other. She then left his room. The only other person in the room was his roommate, Resident V, and he does not hear very well. An interview was conducted with Resident V on 7/31/24 at 2:30 p.m. He indicated a couple of nights ago his roommate, Resident F, had issues with a night shift nurse. He had overheard them in the room arguing back-n-forth about his pain medications. He could not make out every word due to hearing loss, but they were both "nasty" to each other. An interview was conducted with LPN 3 on 7/31/24 at 4:14 p.m. She indicated Resident F used to like her until after his procedure he had this month. The resident's pain medications were decreased and some discontinued after his procedure. He blames her for the discontinuing of his pain medications. Ever since then, he does get upset with her, but will be apologetic afterwards. On 7/24/24, she did not state he was "f****** p****** her off." She did not call him a drug addict. She did indicate to another staff person he was drug seeking. She was unaware if he had overheard the drug seeking statement. An interview was conducted with LPN 11 on 7/31/24 at 4:14 p.m. She indicated Resident F was pleasant to her. A couple of weeks ago, Resident F had stated that he believed LPN 3 did not like		**residents having the potential to be affected by the same deficient practice and what corrective action will be taken?** All residents residing in the facility have the potential to be affected by the alleged deficient practice Residents to be interviewed on or before 08/30/2024 to ensure respect and dignity are exercised and maintained. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?** All Staff will be in-serviced by Director of Nursing or designee on or before 08/30/2024 regarding the facility policy and procedure “Resident Rights” which includes dignity and respect. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?** Corrective actions will be monitored using the QA tool titled, “Resident Rights”. This tool will be used to monitor that Resident Rights are exercised and maintained. This tool will be used	

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	him. He was upset about his pain medication changes after his procedure. He does believe LPN 3 was the reason his pain medications were changed. An interview was conducted with Regional Nurse 1 on 8/1/24 at 10:56 a.m. She indicated if a resident was upset, the staff should be respectful. This citation is related to Complaint IN00434433. 3.1-3(t)		5x/week for 4 weeks, 3x/week for 2 weeks, 2x/week for 2weeks, then weekly for 4 weeks. This QA tool will be reviewed as part of the facilities monthly QAPI meeting to ensure ongoing compliance for a minimum of 6 months and until the facility maintains 100% compliance for 6 months.	
F 0580 SS=D Bldg. 00	483.10(g)(14)(i)-(iv)(15) Notify of Changes (Injury/Decline/Room, etc.) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified			

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	in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). Based on interview and record review, the facility failed to ensure a resident's physician was notified of elevated blood glucose readings per physician's order for 1 of 3 residents reviewed for medication administration. (Resident C) Findings include: The clinical record for Resident C was reviewed on 7/30/24 at 11:30 a.m. The diagnoses included, but was not limited to, diabetes type I, end stage renal disease (ESRD), major depressive disorder, and neuropathy (weakness, numbness, and pain from nerve damage).	F 0580	F580 Notify of Changes Physician Notification What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? • No residents were harmed by the alleged deficient practice. • Staff given education on 08/07/2024 How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken?	08/30/2024

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	An interview with Resident C conducted, on 7/30/24 at 12:17 p.m., indicated, there were numerous times the facility did not administer her insulin, and she had given herself her own insulin from her personal supply she had prior to her admission to the facility. A physician's order, dated 6/21/24, indicated Resident C was to give 10 units of Glargine insulin (long acting insulin) twice daily for diabetes. A physician's order, dated 6/21/24, indicated Resident C was to inject Humalog insulin (short-acting insulin) subcutaneously as per the sliding scale: If blood glucose was 0-199 = 0 units; 200- 250 = 1 unit; 251-300 = 2 units; 301-350 = 3 units; 351- 400 = 4 units; Call medical doctor if blood glucose reading was greater than 400 or below 70; subcutaneously before meals and at bedtime for diabetes. A physician's order, dated 6/20/24, indicated Resident C required a blood glucose check before meals and at bedtime. The instructions were to call the doctor if blood glucose was greater than 400 or below 70. A review of Resident C's July 2024 MAR for blood glucose checks before every meal and at bedtime/Call physician if blood glucose readings greater than 400 or below 70 indicated, on 7/12/24 at 6:00 a.m., and 7/20/24 at 4:00 p.m., Resident C's blood glucose readings were above 400 which required a call to the physician.		• All residents requiring notification to the Provider regarding elevated blood sugars have the potential to be affected by the alleged deficient practice. • All Residents with orders for blood sugar (from the previous 14 days) will be reviewed, if any discrepancies are noted the Provider will be notified immediately for further review. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? • Nursing Staff will be in-serviced by Director of Nursing or designee on or before 08/30/2024 regarding the facility policy and procedure “Notification of Change in Condition” which includes poor glycemic control and notification of physician. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? • Corrective actions will be monitored using the QA tool titled, “Notification of Change in Condition”. This tool will be used to monitor residents with a blood sugar reading requiring notification to the Provider is completed and documented. • This tool will be used 5x/week for	

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	a. On 7/12/24 at 6:00 a.m., the July 2024 MAR indicated Resident C's blood glucose reading at 6:00 a.m. was 461. Resident C's vitals tab indicated, on 7/12/24, two blood glucose readings were completed for the morning. One reading, at 6:14 a.m., indicated a blood glucose reading of 461 and another blood glucose reading, at 6:15 a.m., indicated a bs reading of 400. The clinical record did not contain an explanation of why two readings were conducted nor why the two recordings of her blood glucose, at 6:00 a.m., were different. b. On 7/20/24 at 4:00 p.m., the July 2024 MAR indicated Resident C's blood glucose reading, at 4:00 p.m., was 425. Resident C's vitals tab indicated, on 7/20/24, blood glucose readings, near the 4:00 p.m. time, were completed, at 2:05 p.m., for a reading of 232 and, at 8:39 p.m., a reading of 250 was recorded. It did not contain a blood glucose reading at or around 4:00 p.m. Resident C's progress notes did not indicate the physician was notified of the elevated blood glucose readings on either 7/12/24 or 7/20/24. A medication Administration policy was received, on 7/31/24 at 10:36 a.m., from Regional Nurse 1. The policy indicated the following, ""...the definition of MAR was "the legal documentation for medication administration"...Medications will be charted when given...Medications will be administered within the time frame of one hour before up to one hour after time ordered...Medications that are refused or withheld or not given will be documented...Critical medications that are refused including		4 weeks, 3x/week for 2 weeks, 2x/week for 2weeks, then weekly for 4 weeks. Any discrepancies will be corrected immediately with Provider notification and education will be provided. This QA tool will be reviewed as part of the facilities monthly QAPI meeting to ensure ongoing compliance for a minimum of 6 months and until the facility maintains 100% compliance for 6 months.	

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	insulin...will be followed up with physician contact...Record pertinent information prior to giving medication...blood sugar recorded...Documentation...Documentation of medication will be current for medication administration...Documentation of medications will follow accepted standards of nursing practice."" 3.1-5(a)(3)			
F 0609 SS=D Bldg. 00	483.12(b)(5)(i)(A)(B)(c)(1)(4) Reporting of Alleged Violations §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law,			

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	including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the facility failed to ensure the timely reporting of a resident's unusual swelling of his left thigh/leg, which was identified as a left hip fracture, to the State Survey Agency for 1 of 4 residents reviewed for abuse/neglect. (Resident P) Findings include: The clinical record for Resident P was reviewed on 7/31/24 at 11:30 a.m. The diagnosis included, but was not limited to, paraplegia (chronic condition that affects the lower half of the body, causing loss of muscle function and sensory or motor impairment). A quarterly Minimum Data Set (MDS) assessment, dated 1/19/24, indicated Resident P was cognitively intact and required partial/moderate assistance to transfer from bed to chair and to get in/out of a tub/shower. A Facility Reported Incident, dated 2/2/24 at 8:30 p.m., indicated Resident P had a self-reported fall. The report indicated the type of injury sustained was a left hip fracture. The immediate action taken was Resident P had a self-reported fall to the Nurse Practitioner and his left hip was noted to be swollen. Resident P reported, he was self-transferring and missed his chair and fell. Resident P was sent to the local emergency room for further evaluation. A follow-up, added on 2/7/24, indicated Resident P returned from the hospital and had a surgical intervention to his left hip. The facility reported the incident to the State	F 0609	F609 Reporting of Alleged Violations Timely Reporting What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? • No residents were harmed by the alleged deficient practice. • Resident P was followed up with to ensure medical needs have been met. • Administrator and DON were educated on facility and ISDH reporting policy on 08/01/2024 How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? • No residents were harmed by the alleged deficient practice. • Reportable incidents for all residents will be submitted per ISDH guidelines and the facility's Occurrence Incident Reporting Policy. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? • Nurse Managers will be inserviced by the Administrator and/or DON on the facility's "Occurrence Incident Reporting	08/30/2024

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	Survey Agency on 2/2/24 when the unusual swelling was identified, on 1/29/24, and the subsequent fracture, on 1/31/24, as per the physician's encounter notes indicated. A physician's encounter note, dated 1/29/24 at 1:00 p.m., indicated Resident P was seen for reports of swelling to his left upper leg and stated he woke up with left thigh/leg swollen. Resident P was not sure what caused the swelling. Resident P's Radiology Results Report, dated 1/30/24 at 7:02 p.m., indicated Resident P had a moderately displaced subtrochanteric hip fracture. A physician's encounter note, dated 1/31/24 at 1:00 p.m., indicated Resident P's visit was to review radiology results as Resident P was seen on Monday due to swelling of left upper leg and the x-ray results showed a displaced subtrochanteric hip fracture. They also indicated; Resident P continued to have swelling to his left upper leg. The plan was to send Resident P to the emergency department at the local hospital for evaluation and treatment. A progress note, dated 1/31/24 at 11:16 p.m., indicated Resident P was transferred to the local hospital related to fracture of the left hip. An interview with Regional Nurse 1 conducted, on 7/31/24 at 4:08 p.m., indicated the facility should have reported Resident P's left hip fracture to the State Survey Agency when the x-ray confirmed the fracture. According to Resident P's clinical record, the fracture was identified on 1/31/24. An Abuse & Neglect & Misappropriation of Property policy received, on 7/30/24 at 9:16 a.m.,		Policy" and "ISDH Long-Term Care Abuse and Incident Reporting Policy" on or before 08/30/2024. Nursing Staff will be in-serviced by Director of Nursing or designee on or before 08/30/2024 and on an ongoing basis on the importance of identifying, assessing and reporting occurrences as outlined in "Occurrence Incident Reporting Policy" and "ISDH Long-Term Care Abuse and Incident Reporting Policy" to ensure that staff notify the Administrator and DON to make certain that reporting to ISDH is done in a timely manner. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? • Corrective actions will be monitored using the QA tool titled, "Incident Occurrence". This tool will be used to monitor occurrences that require reporting to ISDH is completed in a timely manner. • This tool will be used 5x/week for 4 weeks, 3x/week for 2 weeks, 2x/week for 2weeks, then weekly for 4 weeks. Any discrepancies will be corrected immediately and education will be provided. This QA tool will be reviewed as part of the facilities monthly QAPI meeting to ensure ongoing compliance for a minimum of 6	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	from the Executive Director indicated the following, '"...the definition of immediate as "CMS (sic, Centers for Medicare and Medicaid) defines immediate as 'as soon as possible but no more than twenty-four (24) hours after an alleged incident is discovered. It is irrelevant where the allegations were unfounded-all alleged violation must be reported immediately...State Reporting and Response...State reportable Occurrences that directly threaten the welfare, safety, or health of a resident...Major accidents...Expected or unintentional events resulting in any fracture or there outcomes that require medication treatment beyond basic first-aide or ER/Physician evaluation...Includes injuries resulting from improper care techniques; Example: 1. All fractures... Instructions for Reporting...An incident identified as mistreatment, neglect, or abuse, including injuries of unknown source...must be reported immediately after providing care and protection for the resident(s) and determines the incident meets the reporting criteria...Initial report- For alleged violations of abuse or if there is resulting serious bodily injury, the facility must report the allegation immediately, but no later than 2 hours after the allegation is made."" This citation is related to Complaint IN00434554. 3.1-28(c)		months and until the facility maintains 100% compliance for 6 months.	
F 0610 SS=D Bldg. 00	483.12(c)(2)-(4) Investigate/Prevent/Correct Alleged Violation §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated.			

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	155272	A. BUILDING 00 B. WING	08/01/2024

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	§483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. Based on interview and record review, the facility failed to thoroughly investigate an allegation of abuse for 1 of 3 reportable incidents reviewed. (Resident N) Findings include: The clinical record for Resident N was reviewed on 8/01/24 at 10:00 a.m. The diagnoses included, but were not limited to, fracture of mandible, fracture of fourth metatarsal bone to right foot, and pain. The resident was admitted on 5/22/24. The resident discharged on 6/11/24. The Admission Minimum Data Set (MDS) assessment, dated 5/29/24, indicated Resident N was cognitively intact. A reportable incident, dated 5/22/24, indicated the following, "...Resident [N] reported that he walked to his door entry and yelled that he was in pain. He stated that the nurse [[License Practical Nurse [LPN] 3]] allegedly told him to get back in bed. Resident stated that later the nurse came to his room and allegedly stated that she would not give him his medication..."	F 0610	F610 Investigate/Prevent/Correct Alleged Violations Thoroughly Investigate an Allegation What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? • No residents were harmed by the alleged deficient practice. • Resident N has discharged from the facility. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? • No residents were harmed by the alleged deficient practice. • Any and all alleged violations will be investigated thoroughly. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?	08/30/2024

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	The complete investigation file for Resident N, dated 5/22/24, was provided by the Regional Nurse 1 on 7/31/24 at 9:09 a.m. The investigation included but was not limited to the following: A typed statement, dated 5/24/24, indicated the following, "...Resident [N] verbalized to unit manager that he had difficulty with the nurse on night shift last night (5/22/24). He stated that he was in pain and walked to his door entry and hollered to the nurse he was in pain. The nurse responded to him 'get your a** back in bed now and don't make me tell you again'. She then came into the room later and said that his medication was here. I said to the nurse 'I imagine I am not going to get that pain med.' The nurse than responded 'You bet your a** you're not.' Reviewed mar [medication administration record] and the nurse administered the pain medication at 4 am [a.m.]...." An email by LPN 3, dated 5/24/24, indicated the following, "...Pt. [patient][Resident N] came out into hallway walking with bedside table...Screaming about his roommates IV [intravenous line] going off. Pt. was very agitated and aggressive. Stating y'all don't hear this s***! I can't f****** sleep with that s***. I told him to stop screaming and don't talk like that. Pt. continues to scream and curse. Stated that his f****** pain medication was every 6 hrs [hours] and we didn't not [sic] give him anything but Tylenol. Pt. walking back to bed stopped and stated push me I dare you. In a very threatening manner. I was never touching pt. but told him he needs to continue to go back to his bed. I placed gloves on and disconnected roommate from IV. This was the pt first day here and I helped Nurse [LPN 5] get him pain medication from EDK		• Nurse Managers will be inserviced by the Administrator and/or DON on the facility's "Resident Grievance Policy" and "ISDH Long-Term Care Abuse and Incident Reporting Policy" on or before 08/30/2024 to ensure that investigations are completed thoroughly. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? • Corrective actions will be monitored using the QA tool titled, "Investigations". This tool will be used to monitor that all allegations are investigated thoroughly. • This tool will be used 5x/week for 4 weeks, 3x/week for 2 weeks, 2x/week for 2weeks, then weekly for 4 weeks. Any discrepancies will be corrected immediately and education will be provided. This QA tool will be reviewed as part of the facilities monthly QAPI meeting to ensure ongoing compliance for a minimum of 6 months and until the facility maintains 100% compliance for 6 months.	

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	[emergency drug kit] before she left. Pt stated you mfs here, f*** this s*** he would go home and self medicate. I told him when its time for him to have another pain pill his nurse would bring it and I don't recommend you get up on your broken hip to get someone to use your call light if you need anything. I only went into room that 1 time bc [because] I was not his nurse. The aid was in before me and he had ask for ice water which she did pass but not her scope to turn IV off. Pharmacy brought his pain meds shortly after and his nurse took it to him. His pain medication was decreased from 2 to 1 tab and changed to Q6 [every 6 hours] which he was upset about...." A typed statement from a nurse working with Resident N, on 5/22/24, dated 5/28/24, indicated the following, "...I did the admission for the resident when he came in. LPN 3 helped me to get the medication out of the EDK at 9:50 p.m. Did you hear and conversation between [Resident N] and [LPN3] - No that had to be after I left which was after 1am [a.m.]. There was no yelling going on. Did you hang the IV for his roommate: Yes, I hanged the IV and it was not completed when I left for the day. No, I did not hear it beeping..." The typed statement, dated 5/28/24, did not indicate the name of the nurse and/or the nurse's signature that verbalized the statement. A typed statement by MDS staff, undated, indicated the following, "During my entry interview with [Resident N] for admission. Resident told me that night shift nurse was rude to him and refused to give him his pain medication. I explained to him that being a new admission our process is different from the hospital and that we have to wait for your prescription to arrive with patient. The (sic) we			

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	can pull from the emergency kit. I explained to him that sometimes hospitals will change medication times. I explained to him that I would relay his concern to the interim DON [Director of Nursing] and SS [social services] and look into his pain medications..." The investigation file did not include statements from the certified nursing assistants (CNAs) and/or the resident's assigned nurse (LPN 6) that had worked the night of 5/22/24. An interview was conducted with Regional Nurse 1 on 8/1/24 at 10:00 a.m. She indicated she was unable to find any additional staff statements for the, 5/22/24, investigation regarding Resident N. She had contacted LPN 6, Resident N's assigned nurse that night, and she had provided a statement that day. A statement by LPN 6, dated 8/1/24, indicated the following, "I was his nurse, I was on break when this happened., he wasn't due for pain medication. [LPN 3] told me he was yelling because his roommates IV was beeping. When I came back from break he didn't ask me for pain medication. He didn't tell me anything about their interaction. He knew I was his nurse because I took him medication when it was due. He never said anything about the interaction with him and [LPN 3]." The staff working schedule, dated 5/22/24, was provided by Regional Nurse 1 on 8/1/24 at 10:30 a.m. It indicated CNA 7, CNA 8, CNA 9 had worked the night shift, on 5/22/24, on the Cambridge Unit. An abuse policy was provided by the Executive Director on 7/30/24 at 9:16 a.m. The policy			

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	indicated the following, "...Policy: It is the policy of this facility to provide resident centered care that meets the psychosocial, physical, and emotional needs and concerns of the residents. It is the intent of this facility to prevent the abuse, mistreatment, or neglect of residents or the misappropriation of their property...Procedure...Investigation of Incident...2. A Suspected Abuse...d. Statement will be obtained from staff related to the incident, including victim, person reporting incident, accused perpetrator and witnesses. This statement should be in writing, signed, and dated at the time it is written. Supervisors may write the statement for a person giving a statement about the incident to them and the person giving the statement must sign and date it, or a third party may witness the statements..." This citation is related to Complaint IN00434554. 3.1-28(d)			
F 0684 SS=D Bldg. 00	483.25 Quality of Care § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. Based on interview and record review, the facility failed to ensure medications were administered as ordered and an Orthopedic appointment and DEXA scan (a bone density test) were scheduled	F 0684	F684 Quality of Care All Treatment and Care Provided to facility residents What corrective action(s) will be accomplished for those residents	08/30/2024

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	in a timely manner for a resident who had an acute distal tibial and fibula fracture for 1 of 4 residents reviewed for abuse and/or neglect and for 1 of 3 residents reviewed for medications. (Resident F and Resident P) Findings include: 1. The clinical record for Resident F was reviewed on 7/31/24 at 9:00 a.m. The diagnosis included, but was not limited to, below the knee amputation (BKA). The Admission Minimum Data Set (MDS) assessment, dated 5/13/24, indicated Resident F was cognitively intact. A care plan, dated 5/7/24, indicated Resident F "has complaints of acute/chronic pain or at risk for pain...Follow physician orders for complaint of pain..." A care plan, dated 5/7/24, indicated Resident F "has impaired skin integrity, or at risk for altered skin integrity r/t [related to] left BKA and opened wound to right shin..." A physician order, dated 6/26/24, indicated Resident F was to receive 15 milligrams of oxycodone every 4 hours for pain. The medication was discontinued on 7/20/24. A hospital discharge summary, dated 7/22/24, indicated Resident F had a procedure of a leg skin graft. The medication summary indicated the resident was to receive 3 tablets of oxycodone twice a day for 7 days. A physician order, dated 7/23/24, indicated Resident F was to receive 15 milligrams of		found to have been affected by the deficient practice? • Resident F's medication orders and MAR were reviewed and updated as needed on 08/01/2024 • Resident P's Orthopedics appt was scheduled for 8/12/2024, Dexa scan completed on 8/12/2024. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? • All residents requiring follow up appointments, imaging and pain medication residing in the facility have the potential to be affected by the alleged deficient practice. • MAR's to be reviewed (from the previous 14 days) on or before 08/30/2024 along with EMR documentation to ensure medications were given and accurately documented. • Resident visit/discharge paperwork (from the previous 14 days) to be reviewed on or before 08/30/2024 regarding outside appointments to ensure follow up and/or imaging appointments are made. • The Provider will be notified in the event of any discrepancies and will be corrected immediately. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur?	

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	oxycodone, three tablets, twice a day for pain. The medication was discontinued on 7/25/24. A controlled drug administration record for 15 milligrams of oxycodone indicated the following days and times Resident F did not receive the three tablets of oxycodone 15 milligrams as ordered: 7/23/24 - 9:00 a.m. - resident received one tablet of 15 milligrams of oxycodone, 7/23/24 - 1:00 p.m., - resident received one tablet of 15 milligrams of oxycodone, and 7/24/24 - 1:00 a.m., - resident received one tablet of 15 milligrams of oxycodone. A physician order, dated 7/25/24, indicated Resident F was to receive a fentanyl patch of 75 micrograms (mcg) every 72 hours. The July 2024 MAR indicated, on 7/28/24, the removal of a fentanyl patch of 75 mcg and an administration of a fentanyl patch of 75 mcg. A controlled drug administration record for Resident F's 75 mcg fentanyl patch indicated the following: 7/26/24 - administered one patch of 75 mcg fentanyl, 7/28/24 - administered one patch of 75 mcg fentanyl, and 7/31/24 - administered one patch of 75 mcg fentanyl. An interview was conducted with Resident F on 7/31/24 at 9:39 a.m. He indicated the staff are "messing up" with his pain medications. After his skin graft surgery, he was supposed to receive three tablets of oxycodone, and he was only		• Nursing Staff will be in-serviced by Director of Nursing or designee on or before 08/30/2024 regarding the facility policy and procedure “Resident Rights” which includes medication administration, laboratory testing and receiving proper medical care. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? • Corrective actions will be monitored using the QA tool titled, “Nursing Review”. This tool will be used to monitor that medications are given, accurately documented in the EMR and follow up appointments/imaging has been scheduled. • This tool will be used 5x/week for 4 weeks, 3x/week for 2 weeks, 2x/week for 2weeks, then weekly for 4 weeks. Any discrepancies will be corrected immediately and education will be provided. This QA tool will be reviewed as part of the facilities monthly QAPI meeting to ensure ongoing compliance for a minimum of 6 months and until the facility maintains 100% compliance for 6 months.	

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	getting one tablet of oxycodone. An interview was conducted with Unit Manager 2 on 7/31/24 at 9:47 a.m. She indicated Resident F had brought it to her attention after his procedure he had not been receiving the correct dosage of his oxycodone. Prior to surgery, he was taking one tablet of oxycodone 15 milligrams. After his surgery, he had received orders to increase his oxycodone 15 milligrams to three tablets. She was unaware of the increase until Resident F had notified her, he had not been receiving the correct dosage. An interview was conducted with Regional Nurse 1 on 7/31/24 at 2:58 p.m. She indicated the staff had administered the fentanyl patch, on 7/26/24, instead of 7/25/24, as the MAR indicates. After administration, the staff did not correct the dates on the MAR. So, Resident F had received another fentanyl patch prior to the 72 hours as ordered. 2. The clinical record for Resident P was reviewed on 7/31/24 at 10:00 a.m. Resident P's diagnosis included, but was not limited to, paraplegia (chronic condition that affects the lower half of the body, causing loss of muscle function and sensory or motor impairment). A Quarterly MDS assessment, dated 1/19/24, indicated Resident P was cognitively intact and required partial to moderate assistance to transfer from bed to chair and to get in/out of a tub/shower. A Facility Reportable provided, on 7/31/24 at 9:09 a.m., from Regional Nurse 1, indicated Resident P, on 5/29/24, had reported that he was having pain in his left ankle. An x-ray was ordered, and the findings indicated he had an acute distal tibial and fibula fracture with callus formation to the left			

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	leg/ankle. The radiology report also indicated the x-ray was suboptimal in detecting subtle osteopenia (bone loss) and recommended a DEXA scan (a bone density test). A physician's encounter note, dated 5/29/24, indicated Resident P was sent to the emergency department of a local hospital for evaluation and treatment of the left ankle. Resident P returned to the facility from the emergency department with a soft cast to left foot and to follow-up with "ortho" (Orthopedics) and will follow-up with DEXA scan for possible cause related to osteopenia. A physician's order, placed on 6/5/24, indicated for Resident P to have a DEXA scan for osteopenia. A physician's order for a referral to orthopedics was placed on 6/6/24. Resident P's clinical record did not contain evidence to support that an appointment for orthopedics had been scheduled nor did it contain evidence to support that the DEXA scan was scheduled/completed. An interview with Transportation Manager conducted, on 8/1/24 at 11:45 a.m., indicated Resident P had an appointment for the DEXA scan, on 6/11/24 at 2:00 p.m., however the ambulance was unable to accommodate a stretcher. Then, on 7/23/24, another appointment had been made for the DEXA scan however, Resident P never received a message that he had an appointment until he received a cancellation notice on his MyChart application. The facility's lack of care coordination resulted in a delay to completing an order for a DEXA scan for Resident P. Transportation Manager indicated Resident P			

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	had a DEXA scan scheduled for 8/19/24, which will be over 2 and a half months since the order for the DEXA scan had been placed. An interview with Unit Manager (UM) 4 conducted, on 8/1/24 at 1:43 p.m., indicated Resident P's appointment with Orthopedics will be on 8/12/24. UM 4 indicated the Orthopedic appointment was scheduled, on 8/1/24, but should have been addressed immediately once the order was received. This citation is related to Complaints IN00434433 and IN00437951. 3.1-37(a)			
F 0697 SS=D Bldg. 00	483.25(k) Pain Management §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Based on interview and record review, the facility failed to assess or address a resident's pain for 1 of 3 residents reviewed for pain. (Resident N) Findings include: The clinical record for Resident N was reviewed on 8/01/24 at 10:00 a.m. The diagnoses included, but were not limited to, fracture of mandible, fracture of fourth metatarsal bone to right foot, and pain. The resident was admitted on 5/22/24. The resident discharged on 6/11/24.	F 0697	F697 Pain Management Assess/Address Residents Pain What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? • No residents were harmed by the alleged deficient practice. • Resident N has discharged from the facility. How will you identify other residents having the potential to be affected by the same deficient	08/30/2024

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	The Admission Minimum Data Set (MDS) assessment, dated 5/29/24, indicated Resident N was cognitively intact. An admission evaluation for Resident N, dated 5/22/24, indicated the following, "...Does the resident complain of pain? yes, Date of pain onset, if known...5/20/24. How frequent does the pain occur? every 4 hours. location of pain - right hip fracture and 4th and 5th toe fractures. Times when pain is worse: morning, night. Feeling of pain: acute...Based on assessment, enter residents severity level of pain (0-10)...8. Resident is to explain what their pain feels like...acute...Ask resident if they had pain, what would be an acceptable level of pain. 3...Ask resident if they ever had pain, how is it relieved? cold, deep relaxation..." A care plan, dated 5/23/24, indicated "[Resident N] has complaints of chronic pain or at risk for pain fracture, impaired mobility r/t [related to] surgical aftercare of hip fracture...Interventions: Administer non-pharmacological interventions (repositioning, diversion activities, snacks and fluids, ice/heat, music therapy, relation techniques, imagery). Complete pain assessment on admission...follow physician order for complain of pain, notify medical provider, resident representative if interventions are unsuccessful, or if current complaint is a significant change from residents past experience of pain, observe for pain every shift..." A physician order, dated 5/22/24, indicated Resident N was to receive 2 tablets of 325 milligrams of Tylenol every 6 hours as needed for pain. A physician order, dated 5/22/24, indicated		practice and what corrective action will be taken? • All residents experiencing pain residing in the facility have the potential to be affected by the alleged deficient practice. • Pain assessments to be completed on all residents on or before 08/30/2024. The Provider will be notified of any concerns. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? • Nursing Staff will be in-serviced by Director of Nursing or designee on or before 08/30/2024 regarding the facility policy and procedure “Pain Management and Assessment” which includes accurately assessing pain, addressing pain and documentation to ensure resident needs have been met. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? • Corrective actions will be monitored using the QA tool titled, “Pain Management”. This tool will be used to monitor that residents experiencing pain is assessed and addressed. • This tool will be used 5x/week for	

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	155272	A. BUILDING 00 B. WING	08/01/2024

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	Resident N was to receive 1 tablet of 7.5-325 milligrams of oxycodone-acetaminophen (generic name of Tylenol) every 6 hours for pain. An investigation file for Resident N, dated 5/22/24, was provided by the Regional Nurse 1 on 7/31/24 at 9:09 a.m. The investigation included but was not limited to the following: A timeline, dated 5/28/24, indicated Resident N was admitted to the facility on 5/22/24 at 7:20 p.m. At 9:50 p.m., Licensed Practical Nurse (LPN) 5 and LPN 3 had pulled 1 tab of 5-325 milligrams of oxycodone-acetaminophen medication out of the emergency drug kit (EDK) and administered to Resident N. After 1:00 a.m., Resident N had requested pain medication from LPN 3. LPN 3 indicated he was unable to receive pain medication at that time, but he could receive a dosage at 4:00 a.m. A typed statement, dated 5/24/24, indicated the following, "...Resident [N] verbalized to unit manager that he had difficulty with the nurse on night shift last night (5/22/24). He stated that he was in pain and walked to his door entry and hollered to the nurse he was in pain. The nurse responded to him 'get your a** back in bed now and don't make me tell you again.' She then came into the room later and said that his medication was here. I said to the nurse 'I imagine I am not going to get that pain med.' The nurse than responded 'You bet your a** you're not.' Reviewed mar [medication administration record] and the nurse administered the pain medication at 4 am [a.m.]..." An email by LPN 3, dated 5/24/24, indicated the following, "...Pt. [patient] came out into hallway walking with bedside table... Stated that his		4 weeks, 3x/week for 2 weeks, 2x/week for 2weeks, then weekly for 4 weeks. Any discrepancies will be reported to the Provider, corrected immediately and education will be provided. This QA tool will be reviewed as part of the facilities monthly QAPI meeting to ensure ongoing compliance for a minimum of 6 months and until the facility maintains 100% compliance for 6 months.	

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	f****** pain medication was every 6 hrs [hours] and we didn't not (sic) give him anything but Tylenol. This was the pt first day here and I helped Nurse [LPN 5] get him pain medication from EDK [emergency drug kit] before she left...I told him when its time for him to have another pain pill his nurse would bring it and I don't recommend you get up on your broken hip to get someone to use your call light if you need anything. I only went into room that 1 time bc [because] I was not his nurse. The aid was in before me and he had ask for ice water which she did pass but not her scope to turn IV off. Pharmacy brought his pain meds shortly after and his nurse took it to him. His pain medication was decreased from 2 to 1 tab and changed to Q6 [every 6 hours] which he was upset about..." A typed statement for a nurse working with resident on 5/22/24, dated 5/28/24, indicated the following, "...I did the admission for the resident when he came in. LPN 3 helped me to get the medication out of the EDK at 9:50 p.m..." A statement by LPN 6 dated 8/1/24 indicated "I was his nurse, I was on break when this happened., he wasn't due for pain medication. [LPN 3] told me he was yelling because his roommates IV was beeping. When I came back from break he didn't ask me for pain medication. He didn't tell me anything about their interaction. He knew I was his nurse because I took him medication when it was due. He never said anything about the interaction with him and [LPN 3]." The resident's clinical record did not indicate the resident's pain was assessed with location of pain or the intensity of pain; nor non-pharmacological interventions were attempted or offered to relieve			

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	the resident's pain. An interview was conducted with Regional Nurse 1 on 8/1/24 at 10:56 a.m. She indicated staff should have addressed Resident N's pain. A pain management and assessment policy was provided by Corporate Nurse 10 on 8/1/24 at 11:59 a.m. It indicated "...Policy: It is the policy of this facility to provide resident centered care that meets the psychosocial, physical and emotional needs and concerns of the residents...The purpose of this policy is to provide guidance to the clinical staff to support the intent of..483.25(k) that based on the comprehensive assessment of a resident, the facility must ensure that residents receive the treatment and care in accordance with professional standards of practice, the comprehensive care plan, and the resident's choices, related to pain management. There is no objective test that can measure pain. The clinician must accept the resident's report of pain. Clinical observations clarify information from the resident. Site of discomfort may direct the nurse to specific types of pain-relief measures...Procedure...II. Pain Scale for Assessing Pain...III. Break-through Pain Management ...c. May require on occasion, adjuvant therapies including pharmacological and non-pharmacological interventions for enhancing pain relief...IV. Non-pharmacological interventions may include but are not limited to: i. room darkening measures ii. uninterrupted time periods for rest and relaxation iii. deep breathing/meditation iv. prayer or other religious activities v. quiet, or soft music background vi. aromatherapy vii. distraction viii. warmth (blankets, thick socks, or room temperature, warm drinks, sunny windows etc.) ix. soups or other 'comfort foods'...VI. Documentation a. medication pain relief and response b. non-pharmacological			

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	measures attempted and the resident response c. care plan updates as needed..." 3.1-37(a)			
F 0755 SS=D Bldg. 00	483.45(a)(b)(1)-(3) Pharmacy Srvcs/Procedures/Pharmacist/Records §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and			

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	periodically reconciled. Based on interview and record review, the facility failed to ensure accurate reconciliation of narcotic medications and assure names and signatures of dispensing nurses were present on the narcotic control record for 1 of 3 residents reviewed for medication administration. (Resident F) Findings include: The clinical record for Resident F was reviewed on 7/31/24 at 9:00 a.m. The diagnosis included, but was not limited to, below the knee amputation (BKA). The Admission Minimum Data Set (MDS) assessment, dated 5/13/24, indicated Resident F was cognitively intact. A physician's order, dated 6/26/24, indicated Resident F was to receive 15 milligrams of oxycodone every 4 hours for pain. The medication was discontinued on 7/20/24. Resident F's controlled drug administration record for 15 milligrams of oxycodone indicated a count of 10 tablets. The record indicated the following documented recordings: On 7/20/24 at 12:00 p.m., a total amount of tablets was 3, 1 tablet was removed with a remaining total of 2 tablets. On 7/20/24 at 4:00 p.m., a total amount of tablets was 2, 1 tablet was removed with a remaining total of 4 tablets. On 7/20/24 at 5:00 p.m., a total amount of tablets was 4 tablets, 1 tablet removed with a remaining total of 1 tablet. On 7/20/24, no time written with no nurse staff signature, 1 tablet removed with zero remaining.	F 0755	F755 Pharmacy Srvcs/Procedures/Pharmacist Records Accurate Reconciliation of Narcotic What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? • No residents were harmed by the alleged deficient practice. • Transcription error was immediately corrected by Licensed Nurse. • Education given to Licensed Nurse. How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? • All residents residing in the facility have the potential to be affected by the alleged deficient practice. • Narcotic Count Sheets (from the previous 14 days) will be reviewed by 08/30/2024 to ensure accuracy in documentation. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? • Nursing Staff will be in-serviced by Director of Nursing or designee on or before 08/30/2024 regarding the facility policy and procedure “Medication Administration” which	08/30/2024

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	Resident F's controlled drug administration record for 15 milligrams of oxycodone indicated a count of 20 tablets. The record indicated the following documented recordings: On 7/21/24, 1 tab was removed with no time indicated nor nurse staff signature totaling a remaining tablet count of 19. On 7/21/24, at unreadable time, 1 tablet was removed with no nurse staff signature totaling a remaining tablet count of 18. An interview was conducted with Resident F on 7/31/24 at 9:39 a.m. He indicated the staff are messing up his pain medications. An interview was conducted with Regional Nurse 1 on 8/1/24 at 10:00 a.m. She indicated Resident F's narcotic count sheets are not accurate or filled out correctly by error. The nurse was coming in to sign the narcotic sheets. She had administered the medications, on 7/21/24, but had forgotten to sign her name. On 7/20/24, the nurse had put the incorrect count of total remaining of 4 tablets left when there was only 2 tablets left. She administered at 4:00 p.m., 1 tablet and 8:00 p.m., 1 tablet. A medication administration policy was provided by Regional Nurse 1 on 7/31/24 at 10:36 a.m. It indicated "...e. Narcotics will be signed out when given..." This citation is related to Complaint IN00434433. 3.1-25(e)(3)		includes accurately documenting removal of pain medication. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place? • Corrective actions will be monitored using the QA tool titled, “Medication Administration”. This tool will be used to monitor that narcotic medication is signed out and counted correctly on the narcotic count sheet and in the EMR when given. • This tool will be used 5x/week for 4 weeks, 3x/week for 2 weeks, 2x/week for 2weeks, then weekly for 4 weeks. Any discrepancies will be corrected immediately and education will be provided. This QA tool will be reviewed as part of the facilities monthly QAPI meeting to ensure ongoing compliance for a minimum of 6 months and until the facility maintains 100% compliance for 6 months.	
F 0842 SS=D Bldg. 00	483.20(f)(5), 483.70(i)(1)-(5) Resident Records - Identifiable Information §483.20(f)(5) Resident-identifiable information.			

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	(i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.			

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	§483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. Based on interview and record review, the facility failed to ensure residents' clinical records were complete and accurate for 1 of 3 residents reviewed for tube feeding and 1 of 3 residents reviewed for medication administration. (Resident C and Resident E) Findings include: 1. The clinical record for Resident E was reviewed on 7/30/24 at 1:00 p.m. The diagnosis included but was not limited to: tracheostomy.	F 0842	F842 Resident Records Ensure Clinical Records were Complete and Accurate What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice? • No residents were harmed by the alleged deficient practice. • Resident C's diabetic orders were reviewed/updated on 08/08/2024 • Resident E's enteral feed orders	08/30/2024

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	A physician order, dated 4/1/24, indicated Resident E was to receive enteral feeding every shift. Staff were to check and record residuals every 8 hours. If residuals were greater than 100 milliliters (ml), hold feeding and notify medical provider. A physician order, dated 4/1/24, indicated Resident E was to receive enteral feeding every shift. The staff was to document the total formula and water intake every shift. The May 2024 Medication Administration Record (MAR), indicated the residuals for Resident E's enteral feeding was recorded on day, evening, and night shift as the following: - day shift: 5/1/24 - NA (nonapplicable), 5/3/24 - 200 ml, 5/6/24 - 480 ml, 5/8/24 - 200 ml, 5/16/24 - 1200 ml, 5/24/24 - 200 ml, 5/28/24 - 480 ml, 5/29/24 - NA, - evening shift: 5/1/24 - 300 ml, 5/6/24 - 480 ml, 5/10/24 - no amount recorded, 5/13/24 - 300 ml, 5/15/24 - 480 ml, 5/19/24 - NA, and - night shift: 5/1/24 - 300 ml, 5/2/24 - 300 ml, 5/10/24 - no amount recorded, 5/14/24 - 300 ml, 5/15/24 - NA, 5/17/24 - NA, 5/19/24 - NA, 5/20/24 -NA, 5/21/24 - NA, 5/22/24 - NA, 5/23/24 - 150 ml. The enteral feeding and water totals indicated the following: The staff recorded NA for 2 of 31 days for the formula and water totals on day shifts. The staff recorded NA for 4 of 31 days for formula and water totals on evening shifts.		were reviewed/updated on 08/08/2024 • Staff educated on documentation on 08/15/2024 How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken? • All residents with diabetic orders and enteral feed orders residing in the facility have the potential to be affected by the alleged deficient practice. • A complete review of all orders for diabetics and enteral feeds (from the previous 14 days) will be completed by 08/30/2024 along with EMR documentation to ensure completion and accuracy. What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur? • Nursing Staff will be in-serviced by Director of Nursing or designee on or before 08/30/2024 regarding the facility policy and procedure “Clinical Documentation Standards” which includes timeliness and accuracy. How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place?	

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	The staff recorded NA for 8 of 31 days for formula and water totals on night shifts. An interview was conducted with Regional Nurse 1 on 7/30/24 at 3:40 p.m. She indicated staff documenting NA was incorrect due to there should be amounts recorded. After review, the resident's residual recordings on 5/1/24, 5/2/24, 5/3/24, 5/6/24, 5/8/24, 5/13/24, 5/16/24, 5/23/24, 5/24/24, and 5/28/24 were formula totals and not residuals. The documentation was recorded in error. 2. The clinical record for Resident C was reviewed on 7/30/24 at 10:45 a.m. Resident C's diagnoses included, but was not limited to, diabetes type I, end stage renal disease (ESRD), major depressive disorder, and neuropathy (weakness, numbness, and pain from nerve damage). An interview with Resident C conducted, on 7/30/24 at 12:17 p.m., indicated there were numerous times the facility did not administer her insulin, and she had given herself her own insulin from her personal supply she had prior her admission to the facility. A physician's order, dated 6/21/24, indicated Resident C was to give 10 units of Glargine insulin (long acting insulin) twice daily for diabetes. A physician's order, dated 6/21/24, indicated Resident C was to inject Humalog insulin (short-acting insulin) subcutaneously as per the sliding scale: If blood glucose was 0-199 = 0 units; 200- 250 = 1 unit; 251-300 = 2 units; 301-350 = 3 units;		• Corrective actions will be monitored using the QA tool titled, “Clinical Documentation Standards”. This tool will be used to monitor that blood sugars and enteral feed orders are documented timely and accurately in the EMR. • This tool will be used 5x/week for 4 weeks, 3x/week for 2 weeks, 2x/week for 2weeks, then weekly for 4 weeks. The Provider will be notified if any discrepancies are found, will be corrected immediately and education will be provided. This QA tool will be reviewed as part of the facilities monthly QAPI meeting to ensure ongoing compliance for a minimum of 6 months and until the facility maintains 100% compliance for 6 months.	

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	351- 400 = 4 units; Call medical doctor if blood glucose greater than 400 or below 70; subcutaneously before meals and at bedtime for diabetes. A physician's order, dated 6/20/24, indicated Resident C required a blood glucose check before meals and at bedtime. Instructions were to call the doctor if blood glucose was greater than 400 or below 70. 2a. On 7/11/24 at 4:00 p.m., the MAR indicated "NA" for the blood glucose reading and was coded as "9" which indicated "other/see nurses notes". The clinical notes did not contain a note concerning why Resident C did not have her blood glucose checked, nor did it contain a blood glucose reading, for 4:00 p.m., in the vitals section of the clinical record. 2b. On 7/17/24 at 8:00 p.m., the MAR indicated "NA" for the blood glucose reading and was coded as "9" which indicated "other/see nurses notes". A nurses note, dated 7/17/24 at 11:59 p.m., indicated Resident C's blood glucose reading was "H+" and called the off-hours physician who indicated to give her 4 units then reassess after an hour and call back. A telehealth provider note, dated 7/18/24 at 12:03 a.m., indicated Resident C was a brittle diabetic and recommended to give 4 units of Humalog per upper limits of "RISS" (sic, regular insulin sliding scale), recheck in an hour, and call back. A nurses note, dated 7/18/24 at 2:14 a.m., indicated, the one-hour follow-up after the telehealth provider was notified about the			

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	155272	A. BUILDING 00 B. WING	08/01/2024

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	resident's hyperglycemia (elevated blood sugar level) and the blood glucose reading was 599. The telehealth provider wanted the resident's blood glucose checked again in an hour. At 2:14 a.m., the blood glucose level had dropped to 485 and telehealth provider suggested 2 units of Humalog and recheck in two hours. An electronic medication administration note dated, 7/18/24 at 4:41 a.m., indicated to inject 2 units of Humalog for a one time only dose for a blood glucose of 485, two units of Humalog given. Rechecked after 2 hours and the blood glucose reading was 295. 2c. On 7/18/24 at 8:00 p.m., the MAR was left blank for both the blood glucose reading and reason if not administered/initials of who administered the medication. The clinical record for Resident C did not contain a note, on 7/18/24, regarding the administration of the Humalog at 8:00 p.m. Under the vital tab in Resident C's clinical record, a blood glucose reading, at 7:52 p.m., indicated she had a blood glucose reading of 400 and, at 9:08 p.m., a reading of 390. According to the resident's Humalog sliding scale, she should have received 4 units of Humalog at 8:00 p.m. 2d. On 7/19/24 at 11:00 a.m., the MAR was left blank for both the blood glucose reading and reason if not administered/initials of who administered the medication. The clinical record for Resident C did not contain a progress note with an explanation of why her blood glucose was not checked at 11:00 a.m., nor did the clinical record contain a blood sugar reading, for 7/19/24, at or around 11:00 a.m.			

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	2e. On 7/20/24 at 11:00 a.m., the MAR was left blank for both the blood glucose reading and reason if not administered/initials of who administered the medication. The clinical record for Resident C did not contain a progress note regarding the 11:00 a.m. blood glucose check nor; did the vitals record indicate a blood glucose check was completed on or around 11:00 a.m. The vitals record indicated, on 7/20/24, blood glucose readings were done, at: 5:45 a.m., then at 1:06 p.m. The blood glucose reading, at 1:06 p.m., was 100. 2f. On 7/24/24 at 11:00 a.m., the MAR indicated "NA" for the blood glucose reading and was coded as "5" which indicated "hold/see nurses notes". Resident C's nurses' notes, from 7/24/24, did not indicate the 11:00 a.m. blood glucose result, nor why it was held nor, did the vitals record indicate a blood glucose check was completed, on or around 11:00 a.m. Blood glucose readings for that day were completed at 7:01 a.m. and 1:39 p.m. A Medication Administration policy, received on 7/31/24 at 10:36 a.m., from Regional Nurse 1, indicated the following, ""...the definition of MAR was "the legal documentation for medication administration"...Medications will be charted when given...Medications will be administered within the time frame of one hour before up to one hour after time ordered...Medications that are refused or withheld or not given will be documented...Critical medications that are refused including insulin...will be followed up with physician contact...Record pertinent information prior to giving medication...blood sugar			

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	recorded...Documentation...Documentation of medication will be current for medication administration...Documentation of medications will follow accepted standards of nursing practice."" This citation is related to Complaints IN00435159, IN00437951and IN00434433. 3.1-50(a)(1) 3.1-50(a)(2)			